

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0042036</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Alden of Waterford</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2003</u> to <u>12/31/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>2021 Randi Dr</u> <u>Aurora</u> <u>60504-4758</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>DuPage</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Steven M. Kroll</u> (Title) <u>Chief Financial Officer</u>																									
Telephone Number: <u>(630) 851-7266</u> Fax # <u>(630) 851-7585</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>																									
IDPA ID Number: <u>36-4151443</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>8/1/2001</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact: Name: <u>Steven M. Kroll</u> Telephone Number: <u>(773) 286-3883</u>																											

STATE OF ILLINOIS

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Facility Name & ID Number Alden of Waterford# 0042036 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF		<u>11,758</u>	<u>10,188</u>	<u>21,946</u>	8
9	SNF/PED					9
10	ICF		<u>751</u>		<u>751</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		<u>12,509</u>	<u>10,188</u>	<u>22,697</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 62.81%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/29/2001

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 77 and days of care provided 10,188Medicare Intermediary Administar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Alden of Waterford

0042036

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	359,041	45,634	5,983	410,658	667	411,325		411,325		1
2	Food Purchase		186,233		186,233	(17,110)	169,123	(7,411)	161,712		2
3	Housekeeping	95,593	21,094		116,687	569	117,256		117,256		3
4	Laundry	31,110	18,391		49,501	180	49,681		49,681		4
5	Heat and Other Utilities			210,349	210,349		210,349	(6,777)	203,572		5
6	Maintenance	47,468		182,534	230,002	(17)	229,985	(37,535)	192,450		6
7	Other (specify):* Security			553	553		553		553		7
8	TOTAL General Services	533,212	271,352	399,419	1,203,983	(15,711)	1,188,272	(51,723)	1,136,549		8
	B. Health Care and Programs										
9	Medical Director			60,900	60,900		60,900		60,900		9
10	Nursing and Medical Records	1,998,775	182,541	11,396	2,192,712	3,594	2,196,306	(82,724)	2,113,582		10
10a	Therapy	112,885			112,885		112,885		112,885		10a
11	Activities	93,346	4,496	4,454	102,296	198	102,494		102,494		11
12	Social Services	28,454			28,454		28,454		28,454		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,233,460	187,037	76,750	2,497,247	3,792	2,501,039	(82,724)	2,418,315		16
	C. General Administration										
17	Administrative	118,135			118,135		118,135		118,135		17
18	Directors Fees										18
19	Professional Services			465,699	465,699		465,699	(444,726)	20,973		19
20	Dues, Fees, Subscriptions & Promotions			30,135	30,135		30,135	(24,961)	5,174		20
21	Clerical & General Office Expenses	338,230	16,506	88,918	443,654	110	443,764	(37,712)	406,052		21
22	Employee Benefits & Payroll Taxes			409,996	409,996	11,809	421,805	18,016	439,821		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,911	3,911		3,911	4,730	8,641		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			63,894	63,894		63,894	11,132	75,026		26
27	Other (specify):* Bad debt expense			91,144	91,144		91,144	(91,144)			27
28	TOTAL General Administration	456,365	16,506	1,153,697	1,626,568	11,919	1,638,487	(564,665)	1,073,822		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,223,037	474,895	1,629,866	5,327,798		5,327,798	(699,112)	4,628,686		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Alden of Waterford

#0042036

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			20,210	20,210		20,210	285,383	305,593			30
31	Amortization of Pre-Op. & Org.							850	850			31
32	Interest							669,662	669,662			32
33	Real Estate Taxes							(2,744)	(2,744)			33
34	Rent-Facility & Grounds			1,054,154	1,054,154		1,054,154	(1,054,154)				34
35	Rent-Equipment & Vehicles			11,387	11,387		11,387	8,718	20,105			35
36	Other (specify):* Mtge Insurance							41,714	41,714			36
37	TOTAL Ownership			1,085,751	1,085,751		1,085,751	(50,571)	1,035,180			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		626,974	988,802	1,615,776		1,615,776	(405,988)	1,209,788			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		626,974	1,043,005	1,669,979		1,669,979	(405,988)	1,263,991			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,223,037	1,101,869	3,758,622	8,083,528		8,083,528	(1,155,671)	6,927,857			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Alden of Waterford

0042036

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(193,644)	30		9
10	Interest and Other Investment Income	(272)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7,104)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(33,440)	21		17
18	Fines and Penalties				18
19	Entertainment	(800)	20		19
20	Contributions	(1,010)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,498)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(91,144)	27		24
25	Fund Raising, Advertising and Promotional	(21,888)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule		21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (352,800)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(376,821)		34
35	Other- Attach Schedule	(426,050)	pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (802,871)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,155,671)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$ n/a		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Alden of Waterford

ID# 0042036

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Late fees on utilities	\$ (8,186)	5	1
2				2
3	Other nursing income (flu,blood,gluc,w/chair,etc)	(22)	21	3
4	Stop payment fee receipt	(25)	21	4
5	Subpoena fee receipt	(20)	21	5
6	Medical records receipts	(48)	10	6
7	Meal receipts	(805)	2	7
8	Misc admin receipts	(665)	21	8
9	IL Health Care Assoc dues (30.13%)	(1,477)	20	9
10	Reclass vendor settlement from line 21	592	21	10
11	Reclass vendor settlement to line 6 (maintenance)	(592)	6	11
12	Back out pr yr vendor settlement (ISSCHI)	592	6	12
13	Back out bank fees charged partnership	(277)	21	13
14	Back out lender late fees charged partnership	(1,724)	21	14
15	To adj depreciation to equal pg 13's (LP is off)	1,905	30	15
16	Back out LP mtge int in excess of CON asset limit	(327,649)	32	16
17	Back out LP MIP in excess of CON asset limit	(21,025)	36	17
18	Marketing Manager (gl 6701-100-009)	(58,562)	21	18
19	Mktg Mgr empl benefits deduction (.018)	(8,062)	22	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(426,050)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden of Waterford

0042036

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,909)	0	0	498	0	0	0	0	0	0	0	(7,411)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(8,186)	0	1,409	0	0	0	0	0	0	0	0	(6,777)	5
6	Maintenance	0	0	4,576	0	0	0	(30)	(42,081)	0	0	0	(37,535)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(16,095)	0	5,985	498	0	0	(30)	(42,081)	0	0	0	(51,723)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(48)	0	0	(80,874)	(1,802)	0	0	0	0	0	0	(82,724)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(48)	0	0	(80,874)	(1,802)	0	0	0	0	0	0	(82,724)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,498)	11,533	(452,761)	0	0	0	0	0	0	0	0	(444,726)	19
20	Fees, Subscriptions & Promotions	(25,175)	0	214	0	0	0	0	0	0	0	0	(24,961)	20
21	Clerical & General Office Expenses	(94,143)	2,328	12,562	25,675	15,866	0	0	0	0	0	0	(37,712)	21
22	Employee Benefits & Payroll Taxes	(8,062)	0	22,462	0	3,616	0	0	0	0	0	0	18,016	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	4,730	0	0	0	0	0	0	0	0	4,730	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	11,022	110	0	0	0	0	0	0	0	0	11,132	26
27	Other (specify):*	(91,144)	0	0	0	0	0	0	0	0	0	0	(91,144)	27
28	TOTAL General Administration	(222,022)	24,883	(412,683)	25,675	19,482	0	0	0	0	0	0	(564,665)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(238,165)	24,883	(406,698)	(54,701)	17,680	0	(30)	(42,081)	0	0	0	(699,112)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden of Waterford

0042036

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(191,739)	464,717	10,584	0	1,821	0	0	0	0	0	0	285,383	30
31	Amortization of Pre-Op. & Org.	0	0	636	0	0	214	0	0	0	0	0	850	31
32	Interest	(327,921)	977,006	18,798	0	1,455	324	0	0	0	0	0	669,662	32
33	Real Estate Taxes	0	(5,991)	2,642	0	605	0	0	0	0	0	0	(2,744)	33
34	Rent-Facility & Grounds	0	(1,054,154)	0	0	0	0	0	0	0	0	0	(1,054,154)	34
35	Rent-Equipment & Vehicles	0	0	8,718	0	0	0	0	0	0	0	0	8,718	35
36	Other (specify):*	(21,025)	62,739	0	0	0	0	0	0	0	0	0	41,714	36
37	TOTAL Ownership	(540,685)	444,317	41,378	0	3,881	538	0	0	0	0	0	(50,571)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(52,046)	(67,232)	(286,710)	0	0	0	0	0	(405,988)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	(52,046)	(67,232)	(286,710)	0	0	0	0	0	(405,988)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(778,850)	469,200	(365,320)	(106,747)	(45,671)	(286,172)	(30)	(42,081)	0	0	0	(1,155,671)	45

Facility Name & ID Number Alden of Waterford

0042036

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden of Waterford Investments, LLC	100%	See Page 6K		See Page 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rent income	\$ 1,054,154	Alden of Waterford Limited Partnership		\$	\$ (1,054,154) 1
2	V	32 Interest income - RR	693	Alden of Waterford Limited Partnership			(693) 2
3	V	19 Accounting fees		Alden of Waterford Limited Partnership		11,349	11,349 3
4	V	19 Professional fees		Alden of Waterford Limited Partnership		184	184 4
5	V	21 Other Administrative		Alden of Waterford Limited Partnership		2,328	2,328 5
6	V	33 Real estate taxes		Alden of Waterford Limited Partnership		(5,991)	(5,991) 6
7	V	26 Property & liability ins		Alden of Waterford Limited Partnership		11,022	11,022 7
8	V	36 Mortgage insurance premium		Alden of Waterford Limited Partnership		62,739	62,739 8
9	V	32 Interest on mortgage		Alden of Waterford Limited Partnership		977,699	977,699 9
10	V	30 Depreciation		Alden of Waterford Limited Partnership		464,717	464,717 10
11	V						
12	V						
13	V						
14	Total		\$ 1,054,847			\$ 1,524,047	\$ * 469,200 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden of Waterford

0042036

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	22 Employee benefits & p/r taxes	\$	Alden Management Services		\$ 22,462	\$ 22,462
16	V	19 Professional fees	459,015	Alden Management Services		6,254	(452,761)
17	V	21 Clerical & general office exp		Alden Management Services		12,562	12,562
18	V	5 Utilities		Alden Management Services		1,409	1,409
19	V	6 Repairs & maintenance		Alden Management Services		4,576	4,576
20	V	24 Travel and seminar		Alden Management Services		4,730	4,730
21	V	26 Insurance		Alden Management Services		110	110
22	V	20 Dues,fees,subscriptions, promo		Alden Management Services		214	214
23	V	30 Depreciation		Alden Management Services		10,584	10,584
24	V	31 Amortization		Alden Management Services		636	636
25	V	33 Real estate taxes		Alden Management Services		2,642	2,642
26	V	35 Rent-equipment/vehicles		Alden Management Services		8,718	8,718
27	V	32 Interest		Alden Management Services		18,798	18,798
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 459,015			\$ 93,695	\$ * (365,320)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden of Waterford

0042036

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 tube-feeding	\$ 6,600	Pyramid Health Care		\$ 7,098	\$ 498
16	V	10 nursing supplies	80,059	Pyramid Health Care		(815)	(80,874)
17	V	39 perdiems/other supplies	113,144	Pyramid Health Care		61,098	(52,046)
18	V	21 gen'l & admin				25,675	25,675
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 199,803			\$ 93,056	\$ * (106,747)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden of Waterford

0042036

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 drugs	\$ 244,796	Forum Extended Care II		\$ 206,806	\$ (37,990)
16	V	10 house stock	11,615	Forum Extended Care II		9,813	(1,802)
17	V	39 I.V.	188,425	Forum Extended Care II		159,183	(29,242)
18	V	22 employee benefits		Forum Extended Care II		3,616	3,616
19	V	21 gen'l & admin		Forum Extended Care II		15,866	15,866
20	V	32 interest		Forum Extended Care II		1,455	1,455
21	V	33 real estate tax		Forum Extended Care II		605	605
22	V	30 depreciation		Forum Extended Care II		1,821	1,821
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 444,836			\$ 399,165	\$ * (45,671)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden of Waterford

0042036

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 therapy	\$ 947,140	Community Physical Therapy		\$ 660,430	\$ (286,710)
16	V	32 interest		Community Physical Therapy		324	324
17	V	31 amortization		Community Physical Therapy		214	214
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 947,140			\$ 660,968	\$ * (286,172)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden of Waterford# 0042036Report Period Beginning: 1/1/2003Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 repairs and maintenance	\$ 9,158	Alden Bennett Construction		\$ 9,128	\$ (30)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 9,158			\$ 9,128	\$ * (30)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden of Waterford

0042036

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 CARPET CLEANING	\$ 9,295	ALDEN REALTY - CARPET CARE		\$ 8,650	\$ (645)
16	V	6 FLOOR CLEANING	2,450	ALDEN REALTY - FLOOR CARE		2,311	(139)
17	V	6 GROUNDS MAINTENANCE	100,980	ALDEN REALTY		59,683	(41,297)
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 112,725			\$ 70,644	\$ * (42,081)

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Alden of Waterford

0042036

Report Period Beginning 01/01/03

Ending: 12/31/03

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Lincoln Park	Chicago
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomington
ANC Village for Children & Young Adults	Bloomington
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomington
Alden of Old Town West	Bloomington
Alden Trails	Bloomington
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
ANC Governor's Park	Barrington

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

STATE OF ILLINOIS

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Facility Name & ID Number Alden of Waterford # 0042036 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	Chief Executive	66.48	339,228	0.844	2.11	Salary	\$ 7,324	17-1	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	0.00	85,225	0.844	2.11	Salary	1,840	10-1	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.00	82,415	0.844	2.11	Salary	1,779	6-1	3
4	Joan Carl d.	Secretary	Vice-President	0.02	213,525	0.844	2.11	Salary	4,610	17-1	4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10	d. Joan Carl is the Secretary of Alden Management Services and all nursing facilities. She has an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12											12
13								TOTAL	\$ 15,553		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden of Waterford# 0042036

Report Period Beginning:

1/1/2003Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, IncStreet Address 4200 W. Peterson AveCity / State / Zip Code Chicago, IL 60646Phone Number (773) 286-3883Fax Number (773) 286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	See Page 8A (also on Page 6A)				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	Heartland Bank of IL		X	Mortgage	\$79,386.00	1/1/02	\$ 12,667,104	\$ 12,589,150	1/1/41	7.7500	\$ 977,699	1							
2	Int related to fixed assets in											2							
3	excess of CON limit		X	Mortgage							(327,649)	3							
4												4							
5												5							
	Working Capital																		
6	Related party - AMS	X		Working capital							18,798	6							
7	Related party-FECH	X		Working capital							1,455	7							
8	Related party - CPT	X		Working capital							324	8							
9	TOTAL Facility Related					\$79,386.00		\$ 12,667,104	\$ 12,589,150			\$ 670,627	9						
	B. Non-Facility Related*																		
10	Interest income on Corp		X	Patient interest income							(272)	10							
11	Waterford LP revenue	X		Non-care interest income							(693)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related							\$	\$			\$ (965)	14						
15	TOTALS (line 9+line14)							\$ 12,667,104	\$ 12,589,150			\$ 669,662	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 41,714 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number Alden of Waterford

0042036 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2002 report.			\$ 75,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$ 37,640	2
3. Under or (over) accrual (line 2 minus line 1).			\$ (37,360)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 31,369	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ (5,991)	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998		8	
	1999		9	
	2000		10	
	2001	64,543	11	
	2002	62,733	12	
FOR OHF USE ONLY				
13	FROM R. E. TAX STATEMENT FOR 2002	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16
Accrual based on expected decrease in valuation.				
Bill reflects total cost. In this case, bill is split between two entities (shared bill). 62,733 x 60% = 37,639				

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden of Waterford COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0042036

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773) 286-3883 FAX #: (773) 286-3743

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>15-36-202-005 *</u>	<u>Nursing Home Facility</u>	\$ <u>62,733.40</u>	\$ <u>37,640.04</u>
2. _____	<u>Related Party - AMS</u>	\$ <u>125,008.00</u>	\$ <u>2,642.00</u>
3. _____	<u>Related Party - FEC II</u>	\$ <u>8,317.00</u>	\$ <u>605.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. <u>* Only 60% is applicable to the</u>	_____	\$ _____	\$ _____
8. <u>provider.</u>	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>196,058.40</u>	\$ <u>40,887.04</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A. Square Feet: 59,206
 B. General Construction Type:
 Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☐ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES ☒ NO
 If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Facility	152,896	1994	\$ 662,733	1
2					2
3	TOTALS	152,896		\$ 662,733	3

Facility Name & ID Number Alden of Waterford

0042036

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99			2001	\$ 11,880,012	\$ 297,000	40	\$ 171,168	\$ (125,832)	\$ 564,427	4
5		Adjustment to correct to CON costs (net=-6,846,713)			(5,033,299)						5
6		related party-forum		1978	15,909		22			15,909	6
7											7
8											8
		Improvement Type**									
9		storm/sewer-ltd p/s		2001	218,336	8,733	25	8,733		20,378	9
10		concrete/curbs/gutters-ltd p/s		2001	21,491	1,433	15	1,433		3,343	10
11		concrete walks-ltd p/s		2001	46,391	3,093	15	3,093		7,217	11
12		asphalt paving-ltd p/s		2001	40,929	4,093	10	4,093		9,550	12
13		street lighting-ltd p/s		2001	129,677	8,645	15	8,645		20,172	13
14		wrought iron fencing-ltd p/s		2001	60,821	2,433	25	2,433		5,677	14
15		piers-ltd p/s		2001	64,296	4,286	15	4,286		10,001	15
16		exterior signs-ltd p/s		2001	20,853	1,738	12	1,738		4,055	16
17		brick pavers-ltd p/s		2001	5,213	521	10	521		1,216	17
18		waterfalls-ltd p/s		2001	53,870	2,693	20	2,693		6,284	18
19		gate house-ltd p/s		2001	26,066	1,738	15	1,738		4,055	19
20		retaining walls-ltd p/s		2001	19,115	956	20	956		2,230	20
21		external roads-ltd p/s		2001	261,213	26,121	10	26,121		60,949	21
22		Mech. Projects- intall exhaust,gas line, electric to steamer-corp		2002	4,254	213	20	213		425	22
23		Long elevator- correct elevator problem-corp		2001	882	88	10	88		184	23
24		Affcus- repair fire alarm-corp		2002	1,552	310	5	310		621	24
25		GT Mech- chiller repair-corp		2002	1,924	385	5	385		769	25
26		ISS replace nurses station		2003	1,956	326	5	326		326	26
27											27
28		storm/sewer-ltd p/s		2003	16,853	674	25	674		674	28
29		concrete/curbs/gutters-ltd p/s		2003	1,659	111	15	111		111	29
30		concrete walks-ltd p/s		2003	3,581	239	15	239		239	30
31		asphalt paving-ltd p/s		2003	3,159	316	10	316		316	31
32		street lighting-ltd p/s		2003	10,009	667	15	667		667	32
33		wrought iron fencing-ltd p/s		2003	4,695	188	25	188		188	33
34		piers-ltd p/s		2003	4,963	331	15	331		331	34
35		exterior signs-ltd p/s		2003	1,610	134	12	134		134	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38	brick pavers-ltd p/s	2003	402	40	10	40		40	38
39	waterfalls-ltd p/s	2003	4,158	208	20	208		208	39
40	gate house-ltd p/s	2003	2,012	134	15	134		134	40
41	retaining walls-ltd p/s	2003	1,475	74	20	74		74	41
42	external roads-ltd p/s	2003	20,163	2,016	10	2,016		2,016	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,916,198	\$ 369,937		\$ 244,105	\$ (125,832)	\$ 742,920	70

**Improvement type must be detailed in order for the cost report to be considered complete.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,916,198	\$ 369,937		\$ 244,105	\$ (125,832)	\$ 742,920	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	16,755		20			16,755	4
5	Leasehold Improvement-Remodeling	1980	1,047		10			1,047	5
6	Leasehold Improvement-Remodeling	1986	559		5			559	6
7	Leasehold Improvement-Remodeling	1990	350		5			350	7
8	Leasehold Improvement-Remodeling	1991	82		5			82	8
9	Leasehold Improvement-Remodeling	1993	7,732		10			7,732	9
10	Leasehold Improvement-Remodeling	1993	6,056		9.7			6,056	10
11	Leasehold Improvement-sign	1994	226	14	12	14		120	11
12	Leasehold Improvement-dryvit	1995	384	24	10	24		203	12
13	Leasehold Improvement-new ac	1999	626	39	15	39		203	13
14	Leasehold Improvement-roof	1985	843	44	19	44		843	14
15	Leasehold Improvement-roof	1994	748	47	15	47		529	15
16	Leasehold Improvement-roof	1997	710	44	15	44		349	16
17	Leasehold Improvement-roof	1998	1,205	75	15	75		507	17
18	Leasehold Improvement-parking lot asphalt	2000	96	32	10	32		63	18
19	Leasehold Improvement-hallway lighting	2001	135	27	10	27		56	19
20	Leasehold Improvement-DAI	2001	169	17	10	17		53	20
21	Leasehold Improvement-bathrooms	2002	630	63	10	63		80	21
22	Leasehold Improvement-Remodeling	2002	91	18	5	18		36	22
23	Leasehold Improvements-Remodeling	2003	1,638	164	10	164		164	23
24	Leasehold Improvements-Remodeling	2003	105	4	4	4		4	24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	6,132		7			6,132	27
28	Leasehold Improvement-Remodeling	2002	5,020	627	7	627		4,392	28
29	Leasehold Improvement-Remodeling	2003	5,251	660	7	660		4,611	29
30									30
31									31
32									32
33		1999	15,137	378	40	378		1,896	33
34	TOTAL (lines 1 thru 33)		\$ 7,987,925	\$ 372,214		\$ 246,382	\$ (125,832)	\$ 795,742	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 552,486	\$ 108,624	\$ 40,812	\$ (67,812)	varies	\$ 139,702	71
72	Current Year Purchases	32,920	2,527	2,527		varies	2,527	72
73	Fully Depreciated Assets	40,851	1,098	1,098		varies	40,851	73
74								74
75	TOTALS	\$ 626,257	\$ 112,249	\$ 44,437	\$ (67,812)		\$ 183,080	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car engine/bus/van	:dodge/other	98-'03	\$ 11,860	\$ 2,052	\$ 2,052		3	\$ 11,658	76
77	passenger bus	2001 Ford Eldorado	2001	50,888	12,722	12,722		4	30,745	77
78										78
79										79
80	TOTALS			\$ 62,748	\$ 14,774	\$ 14,774			\$ 42,403	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,339,663	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 499,237	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 305,593	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (193,644)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,021,225	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	n/a	\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$		91

G. Construction-in-Progress

	Description	Cost	
92	n/a	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related party - cost is eliminated

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 6,150 Description: Copy machine lease

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Transport-non-patients</u>		\$ <u>436.00</u>	\$ <u>5,237</u>	17
18					18
19	<u>Related party-AMS</u>		<u>727.00</u>	<u>8,718</u>	19
20					20
21	TOTAL		\$ <u>1,163.00</u>	\$ <u>13,955</u>	21

10. Effective dates of current rental agreement:

Beginning 5/1/2001
Ending 4/30/2011

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/2004 \$ Varies
13. 12/2005 \$ Varies
14. 12/2006 \$ Varies

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>Skilled nurses on site</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 366,653	\$		\$ 366,653	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			95,427			95,427	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			392,550			392,550	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Page 16A	# of prescrpts				181,054		181,054	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	See Page 16A					174,104		174,104	13
14	TOTAL			\$		\$ 854,630	\$ 355,158		\$ 1,209,788	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Alden - Waterford Rehab

Page 16
Col 5: PT,OT, & ST
Col 6: Other
Amount

XIV. SPECIAL SERVICES (Direct Cost)

Service

1. OT	39-3	\$366,654.00
2. ST	39-3	95,427.00
3.		
4. PT	39-3	392,550.00
5.		
6.		
7.		
8.		
9. Pharmacy	See pg 16A	248,285.70
Plus: Related Party- Forum Drugs		(37,990.00)
Plus: Related Party- Forum I.V.		(29,242.00)
Total to line 9 Pharmacy		181,053.70
10.		
11.		
12. Exceptional Care-Column 3	See pg 16A	0.00
12. Exceptional Care-Column 6	See pg 16A	0.00
13. Other	See pg 16A	512,859.56
Related Party- Pyramid		(52,046.00)
Related Party- CPT		(286,709.61)
Total to line 13		174,103.95
14. Total		1,209,788.65

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Alden of Waterford

0042036

Report Period Beginning: 1/1/2003

Ending:

12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (100,670)	\$ (100,274)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 80,000)	1,203,516	1,203,516	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		94,659	5
6	Prepaid Insurance	786	9,766	6
7	Other Prepaid Expenses	775	5,999	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,104,407	\$ 1,213,666	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		662,733	13
14	Buildings, at Historical Cost		11,880,012	14
15	Leasehold Improvements, at Historical Cost	10,567	1,053,653	15
16	Equipment, at Historical Cost	112,223	1,620,436	16
17	Accumulated Depreciation (book methods)	(42,557)	(1,120,055)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 80,233	\$ 14,096,779	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,184,640	\$ 15,310,445	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,591,311	\$ 2,591,311	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,706	7,706	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	228,125	228,125	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,592	22,592	31
32	Accrued Real Estate Taxes(Sch.IX-B)		31,369	32
33	Accrued Interest Payable		81,305	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued exp/ins/sales tax	53,380	53,380	36
37	Due to Affiliates & 3rd parties	1,903,180	2,442,591	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,806,294	\$ 5,458,379	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,589,150	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 12,589,150	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,806,294	\$ 18,047,529	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,621,654)	\$ (2,737,084)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,184,640	\$ 15,310,445	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,008,136)	1
2	Restatements (describe):		2
3	External audit adjustments made after 2002 cost	20,002	3
4	report was submitted. These have no effect on prior yr's		4
5	report: bad debt, medicare revenues (non-allowable)		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,988,134)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,633,520)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,633,520)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,621,654)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,103,877	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,103,877	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(2,530)	6
7	Oxygen	3,149	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 619	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	165	12
13	Barber and Beauty Care	1,719	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	10,388	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,963	19
20	Radiology and X-Ray		20
21	Other Medical Services	142,827	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 158,062	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	272	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 272	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Various - See attached	1,563	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,563	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,264,393	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,203,983	31
32	Health Care	2,497,247	32
33	General Administration	1,626,568	33
	B. Capital Expense		
34	Ownership	1,085,751	34
	C. Ancillary Expense		
35	Special Cost Centers	1,615,776	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37	Related party salary allocation located in		37
38	column 1 on pages 3 and 4	(185,615)	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,897,913	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,633,520)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,633,520)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number Alden of Waterford

0042036

Report Period Beginning: 1/1/2003

Ending:

12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,023	2,054	\$ 68,120	\$ 33.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,341	26,131	727,235	27.83	3
4	Licensed Practical Nurses	13,353	13,776	327,892	23.80	4
5	Nurse Aides & Orderlies	57,256	59,617	810,859	13.60	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,511	3,665	49,304	13.45	8
9	Activity Director	2,069	2,220	40,593	18.29	9
10	Activity Assistants	6,217	6,367	52,753	8.29	10
11	Social Service Workers	1,264	1,322	28,454	21.52	11
12	Dietician					12
13	Food Service Supervisor	1,707	1,783	33,816	18.97	13
14	Head Cook	5,428	5,689	87,004	15.29	14
15	Cook Helpers/Assistants	26,531	27,253	236,097	8.66	15
16	Dishwashers					16
17	Maintenance Workers	1,847	1,919	38,774	20.21	17
18	Housekeepers	13,606	14,074	92,415	6.57	18
19	Laundry	4,234	4,343	31,110	7.16	19
20	Administrator	1,603	1,648	70,952	43.05	20
21	Assistant Administrator	720	720	17,448	24.23	21
22	Other Administrative	6,448	6,597	134,234	20.35	22
23	Office Manager					23
24	Clerical	6,610	6,750	75,323	11.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,781	1,878	51,458	27.40	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Clinical SS	2,162	2,234	63,581	28.46	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	183,711	190,040	\$ 3,037,422 *	\$ 15.98	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	\$ 5,983	1-3	35
36	Medical Director	monthly	68,200	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	2,376		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,334	11-3	44
45	Social Service Consultant	16	876	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	40	\$ 78,769		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ n/a		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
Panaligan, J	Administrator		\$ 70,953	Workers' Compensation Insurance		\$ 36,644	IDPH License Fee		\$		
				Unemployment Compensation Insurance		52,196	Advertising: Employee Recruitment		412		
Various execs/asst admin	executive admin		29,734	FICA Taxes		225,444	Health Care Worker Background Check (Indicate # of checks performed <u>72</u>)		1,001		
				Employee Health Insurance		23,791					
Nhim, V	ass't administration		17,448	Employee Meals		17,110	Related party-AMS		214		
				Illinois Municipal Retirement Fund (IMRF)*			Compumax renewal		123		
				Related party-AMS		22,462	IL Health Care Assoc		3,424		
				Related party-FECII		3,616					
				Union,health,welfare		35,077					
				Dental,pension,life		19,764					
				Empl relation/misc p/r		256					
				Employee drug tests & vaccinations		11,523	Less: Public Relations Expense		(
				Mktg empl benefit deduction		(8,062)	Non-allowable advertising		(
							Yellow page advertising		(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 118,135	TOTAL (agree to Schedule V, line 22, col.8)		\$ 439,821	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 5,174		
B. Administrative - Other											
Description			Amount								
			\$								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees							
C. Professional Services				Description		Line #	Amount				
Vendor/Payee	Type		Amount								
AMS	Management fees		\$ 459,015								
Ken Fisch	Legal fees (collections)		3,498								
Ken Fisch	Legal fees (non-collection)		1,870								
MediCom	Billing consulting		194								
Law Offices of Chicago-Kent	Workers comp cases		650								
EJ Molloy & Assoc	Site surveys		472								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 465,699	TOTAL		\$	G. Schedule of Travel and Seminar**				
							Description				
							Amount				
							Out-of-State Travel				
							\$				
							In-State Travel				
							Related party-AMS				
							Gas expense				
							Ins, license, repairs				
							Seminar Expense				
							Lifetime Fitness stress/team build				
							Triton College course				
							Medicaid/MDS seminars				
							Entertainment Expense				
							(
							(agree to Sch. V, line 24, col. 8)				
							TOTAL				
							\$ 8,641				

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Alden of Waterford

STATE OF ILLINOIS

0042036

Report Period Beginning:

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. 4901
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,321 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 54,203
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 17,110 Has any meal income been offset against related costs? yes Indicate the amount. \$ 588
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. audit not required
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

Alden of waterford Rehab & Health Care Center
Reporting Period Beginning
Reporting Period Ending

#0041277
1/01/03
12/31/03

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Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2		(17,110)	Employee Meal
	22	17,110	Employee Meal
22		(5,301)	Uniforms
	10	3,594	Uniforms
	6	(17)	Uniforms
	4	180	Uniforms
	1	667	Uniforms
	3	569	Uniforms
	11	198	Uniforms
	21	110	Uniforms
		<hr/>	
		0	Net should be 0